TITLE 469
ASSISTANCE TO THE AGED, BLIND, OR DISABLED (AABD NEBRASKA MEDICAL ASSISTANCE PROGRAM (NMAP), AND STATE DISABILITY PROGRAM (SDP)

CHAPTER 1-000 GENERAL BACKGROUND

1-001 Legal Basis: Assistance to the Aged, Blind, or Disabled (AABD) was established by the Nebraska Legislature in 1965 by Section 68-1001 Reissue Revised Statutes of Nebraska, 1986. It replaces former programs of Old Age Assistance, Blind Assistance, and Aid to the Disabled.

Medicaid was established by Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Sec. 68-1018, R.R.S., 1986. SDP was established by the Nebraska Legislature in 1975.

1-002 Purpose and Scope: The AABD Program was established to provide financial aid and medical assistance to persons in need who are age 65 and older, or who are age 64 and younger and blind or disabled according to the Retirement, Survivors, and Disabled Insurance (RSDI)/Supplemental Security Income (SSI) Program definition of blindness or disability (see 469 NAC 2-007.02).

The State Disability Program was established to provide financial aid and medical assistance to persons who are blind or disabled and who meet the program definition of blindness or disability (see 469 NAC 2-007.02) but do not meet the durational requirements.

NMAP, also known as Medicaid, provides medical services to aged, blind, or disabled persons, who are otherwise eligible and who do not have sufficient income and resources to meet their medical needs.

The maintenance portion of the AABD and SD Programs is funded entirely by state money. The medical assistance portion of the AABD Program is funded by federal and state money. For SDP, the medical assistance portion is funded by state dollars.

1-003 Administration: AABD, NMAP, and SDP are administered by the Nebraska Department of Social Services in accordance with state laws and with the rules, regulations, and procedures established by the Director of the Nebraska Department of Social Services.

1-004 Definition of Terms: For use within AABD, NMAP, and SDP, the following definitions of terms will apply unless the context in which the term is used denotes otherwise.

AABD/MA: A categorical program consisting of financial assistance and medical assistance or medical assistance only. Two types of cases are included in the medical assistance only category:

1. Medical Assistance With No Share of Cost (MA only): A case in which there is income sufficient to meet daily maintenance needs but insufficient to meet medical needs. The case is opened for medical assistance only with no grant payment; and
2. AABD/Medical Assistance Share of Cost Case (MA with Share of Cost): A case in which there is sufficient income to meet daily maintenance needs and a portion but not all of the unit's medical needs. The case is opened for medical assistance with no payment for medical services made until the Share of Cost is obligated toward medical services.

Adequate Notice: Notice of case action which includes a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s), (see also 469 NAC 1-008.03C).

Aged: A client who is age 65 or older.

Applicant: An individual who applies for assistance.

Application: The action by which the individual indicates in writing the desire to receive assistance.

Application Date: For new and reopened cases, the date a properly signed application is received. When adding a program to a properly signed application, this is the date that the new program is requested.

Approval/Rejection Date: The date that the new or reopened case is determined eligible or rejected by the Nebraska Department of Health and Human Services.

Assignment: The legal transfer of an individual's right to benefits to the Nebraska Department of Health and Human Services.

Blind: A category of eligibility for clients who are age 64 and younger and who are blind in accordance with program standards.

Categorical Assistance: Assistance administered by the Nebraska Department of Social Services. For the purposes of this definition, it includes Aid to Dependent Children (ADC)/MA, Child Welfare Payment and Medical Services Program/MA, AABD/MA, SDP/MA, Refugee Resettlement Program/MA; and Children's Medical Assistance Programs.

Client: An individual either applying for or receiving assistance. This term is used when the same policies apply to an applicant and a recipient.

Deeming: The process of determining the amount of income and resources of a parent or sponsor which must be considered available to meet the client's needs.

Disabled: A category of eligibility for clients who are age 64 and younger and who are disabled in accordance with program standards.

Equity: The fair market value of property minus the total amount owed on it.

Essential Person (EP): A needy individual -

1. Who lives in the home of the client;
2. Who is not eligible for assistance in his/her own right;
3. Who is necessary to the well-being of the client; and
4. Whose needs are included in the client's budget.

This determination is made by SSI or by the client.

For EP's included in determining a payment budget, see 469 NAC 3-006.02 ff. For EP's included in determining eligibility for NMAP, see 469 NAC 4-007.

Fair Market Value: The price an item of a particular make, model, size, material, or condition will sell for on the open market in the geographic area involved.

Grant Case: A case receiving a state supplement payment, or eligible to receive a grant payment which is nullified by an SSI payment.

Inquiry: Any question received by phone, letter, or personal contact without any indication that the individual wishes to apply. This may or may not be followed by a request or application for assistance.

Need: A condition of eligibility referring to economic need.

Needy Individual: One whose income and resources for maintenance are found under assistance standards to be insufficient for meeting the basic requirements (see also 469 NAC 2-009 ff. and 2-010 ff.).

Payment Effective Date: The month and year that the grant payment is to be effective.

Pending Case: A case in which the application has been taken and eligibility is yet undetermined. All pending cases must be entered on N-FOCUS within two working days.

Power of Attorney: A written statement allowing one person to act for another person. A power of attorney may be authorized generally for the management of a specified business or enterprise or more often specifically for the accomplishment of a particular transaction. There is no court involvement or supervision in the appointment. The statement does not have to be notarized.

A standard or non-durable power of attorney automatically becomes null and void when the appointing individual becomes incompetent. A durable power of attorney continues in effect even when the appointing individual becomes incompetent. The power of attorney document should clearly specify if it is a durable power of attorney.

Prospective Eligibility for Medical Assistance: The date of eligibility beginning the first day of the month of the date of request if the client was eligible for MA in that same month.

Prudent Person Principle: The practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information before determining initial or continuing eligibility (see also 469 NAC 1-010).

Recipient: An individual who is receiving assistance.

Rejected Case: A case in which an application was completed and signed but the applicant did not meet the categorical, procedural, or financial requirements of the program.

Request: An action by which an individual's desire to receive assistance is made known to the local office. A request may be made by telephone, letter, or an interview.

Request Date: The date the client requests assistance. For reopened cases, this is the date of the new request. For program changes, this is the request date for the new program.

Retroactive Eligibility for Medical Assistance: The date of eligibility beginning no earlier than the first day of the third month before the month of request if the following conditions were met:

1. Eligibility was determined and a budget computed separately for each of the three months;
2. A medical need existed; and
3. Eligibility requirements were met at some time during each month.

Retroactive Payment: Any payment made during the current month but for a prior month.

Share of Cost: A client's financial out-of-pocket obligation for medical services when countable income exceeds the medical maintenance income level. The Share of Cost amount is the difference between the unit's countable income and the appropriate medical maintenance income level. This amount must be obligated or paid to medical providers before Medicaid will pay on the remaining medical bills.

SDP/MA: A categorical program consisting of financial assistance and medical assistance or medical assistance only. Two types of cases are included in the medical assistance only category:

1. Medical Assistance With No Share of Cost (SOC) (MA only): A case in which there is income sufficient to meet daily maintenance needs but insufficient to meet medical needs. The case is opened for medical assistance only with no grant payment; and
2. SDP/Medical Assistance SOC Case: A case in which there is sufficient income to meet daily maintenance needs and a portion but not all of the unit's medical needs. The case is opened for medical assistance with no payment for medical services made until the SOC is obligated toward medical services.

SSI Federal Benefit Rate: The maximum SSI benefit payable based on the individual's living arrangement, e.g., own home, nursing home, living in another's home.

Supplemental Payment: Any payment made for and during the current month after major payroll has run.

Third Party Medical Payment: A payment from any health insurance plan, individual, or group for medical expenses.

Timely Notice: A notice of case action dated and mailed at least ten calendar days before the date the action becomes effective (see 469 NAC 1-008.03A2).

Unit: Eligible/needy individuals considered in determining the grant and/or medical assistance.

Withdrawal: A voluntary written retraction of an application.

1-005 Worker Responsibilities: The worker has the following responsibilities.

1-005.01 Duties at Initial Application or Redetermination: At the time of initial application and redetermination, the worker shall -

1. Allow anyone who requests assistance to complete an application;
2. Give an explanation of the program requirements;
3. Collect and review the information entered on the application form;
4. Explain the eligibility and payment factors and how changes will affect eligibility and payment;
5. Explain the eligibility and payment factors that require verification;
6. Obtain the client's written consent for the needed verifications;
7. Explore income that may be currently or potentially available such as RSDI, SSI, Veteran's Assistance benefits (VA), etc.;
8. Give information about the social and other financial services available through the agency, such as social services and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
9. Inform the client about his/her rights and responsibilities (see 469 NAC 1-006 and 1-007);
10. Inform the client that s/he must show his/her medical card to all providers and must inform the worker of any health insurance plan, any individual, or any group that may be liable for the client's medical expenses;
11. Explain the assignment of third party medical payments and the requirement to cooperate in obtaining third party medical payments and refund any payments received directly;
12. Inform the client of the requirement to participate in the Nebraska Health Connection, if applicable (see 469 NAC 4-009 ff.)
13. Complete necessary reports and information forms;
14. Act with reasonable promptness on the client's application for assistance;
15. Provide adequate notice to the client of -
    a. Approval for a grant and the amount;
    b. Approval for medical assistance;
    c. Rejection of the application and the reason; or
    d. Confirmation of the client's voluntary withdrawal; and
16. Explain the appeal process (see 465 NAC 2-001.02 ff.).

{Effective 7/25/95}

1-005.02 Continuing Responsibilities: The worker has the continuing responsibility to:

1. Provide adequate notice of any action affecting the client's assistance case (see 469 NAC 1-008.03 ff. to determine if timely notice is necessary);
2. Treat the client's information confidentially; and
3. Uphold the client's civil rights.

1-005.03 Nursing Facility Admissions: The worker must refer any client requesting nursing facility services to the admitting nursing facility for the identification screen and Pre-Admission Screening Process (PASP) as required by 471 NAC 12-000 ff.

1-006 Client Responsibilities: The client is required to:

1. Provide complete and accurate information. State and federal law provides penalties of a fine, imprisonment, or both for persons found guilty of obtaining assistance or services for which they are not eligible by making false statements or failing to report promptly any changes in their circumstances;
2. Report a change in circumstances no later than ten days following the change. This includes information regarding:
   a. Monthly expenses;
   b. Resources or other financial matters;
   c. Employment status;
   d. The composition of the household;
   e. Living arrangements;
   f. Address;
   g. Disability status;
   h. A temporary absence from the home of any unit member; and
   i. Changes in the amount of monthly income, including -
      (1) All changes in unearned income; and
      (2) Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for AABD, 30 hours per week is considered full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change.
3. Present his/her medical card to providers;
4. Inform the medical provider and worker of any health insurance plan, any individual, or any group that may be liable for his/her medical expenses;
5. Cooperate in obtaining any third party medical payments;
6. Enroll in a health plan and maintain enrollment if:
   a. One is available to the client;
   b. The client is able to enroll on his/her own behalf; and
   c. The Department has determined that enrollment in the plan is cost effective.
7. Reimburse to the Nebraska Department of Health and Human Services or pay to the provider any third party medical payments received directly for services which are payable by the Nebraska Medical Assistance Program;
8. Pay any unauthorized medical expenses;
9. Pay any required medical copayment (see 469 NAC 4-008 ff.);
10. Meet the requirements of the Nebraska Health Connection, if applicable (see 469 NAC 4-009); and
11. Cooperate with state and federal quality control.

1-006.01 Sanction for Non-Cooperation With Quality Control: A client must cooperate with state and federal quality control as a condition of eligibility. If a client fails to cooperate, s/he is ineligible for one month only. The worker closes the case the first month possible, considering adequate and timely notice. The following month, the worker reopens the case if the client is otherwise eligible. If at anytime QC notifies the worker that the client has cooperated, assistance is restored for the month the case was closed.

1-007 Client Rights: The client has the right to:

1. Apply. Anyone who wishes to request and/or apply for assistance must be given the opportunity to do so. No one may be denied the right to apply for public assistance;
2. Reasonably prompt action on his/her application for assistance (see 469 NAC 1-008.02B);
3. Adequate notice of any action affecting his/her application or assistance case (see 469 NAC 1-008.03 ff. to determine if timely notice is necessary);
4. Appeal to the Director for a hearing on any action or inaction with regard to an application, the amount of the assistance payment, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the action or inaction;
5. Have his/her information treated confidentially;
6. Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, or political belief;
7. Have the program requirements and benefits fully explained;
8. Be assisted in the application process by the person of his/her choice;
9. Receive medical assistance without a separate application if s/he is eligible for categorical assistance; and
10. Referral to other agencies.

1-008 Application Processing

1-008.01 Request: A request for assistance may be made in an interview, by letter, or by telephone, and may be made by the applicant, his/her guardian or conservator, an individual acting under a duly executed power of attorney (see 469 NAC 1-004), or another person authorized to act for the applicant. The worker must record the request date on the application. If an interview cannot be scheduled within 14 days from the date of request, an application must be mailed promptly.

A request is terminated:

1. When a properly signed application is received;
2. When the applicant or his/her representative notifies the worker of withdrawal; or
3. After 30 days if the worker has heard nothing further from the applicant or his/her representative. However, the worker may continue to hold a request pending if there is reason to believe the applicant intends to complete his/her application.

1-008.02 Application: A request becomes an application when a properly signed application is received. A properly signed application contains:

1. Name;
2. Address; and
3. Proper signature, as defined by the appropriate program.

An application may be signed by an individual for himself/herself or by the applicant's guardian, conservator, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant. The worker must use prudent person principle in deciding who may sign the application.

An application for medical benefits only may be taken on behalf of a deceased person. If there is no one to represent the deceased person, the administrator of the estate may sign the application. The eligibility requirements must have been met at the time medical services were rendered.

1-008.02A Alterations: The application, when completed and signed by the client or his/her representative, constitutes his/her own statement in regard to his/her eligibility. If the worker adds information received from a client to a properly signed application, the worker must date the information and:

1. Request that the client initial the change, if the client is present; or
2. Identify the source of the information, if the client is not present.

If a substantial amount of information is added during the face-to- face interview, the worker may request that the client sign and date the application again.

The worker may alter an initial application up to the date of approval. An application for a redetermination may be altered up to the date the redetermination has been completed.

1-008.02B Prompt Action on Applications: The worker shall act with reasonable promptness on all applications for assistance. The worker shall make a determination of eligibility on an application within 45 days from the date of the request for a client applying under the blind or aged category and within 60 days from the date of request for a client applying under the disabled category. If circumstances beyond the control of the worker prevent action within the required time, the worker shall record the reason for the delay in the case record. The worker shall send Form IM-8 informing the applicant of the reason for the delay. The 45 or 60-day time period must not be used as a routine waiting period before approving assistance. Until a determination of eligibility is made, the worker shall send Form IM-8 every 45 days from the date of request for a pending application for the blind or aged category and every 60 days for the disabled category.

1-008.02C MA Application With Excess Income: An application for medical assistance for an individual with excess income who has a medical need may be approved with no medical payments authorized until the applicant has met his/her obligation.

1-008.02D Application With Excess Resources: An application for assistance for an individual who has excess resources may be held pending until the resources are reduced. For resource spenddown procedures, see 469 NAC 2-009.11.

For eligibility for a grant, see 469 NAC 2-009.08. For medical eligibility, see 469 NAC 4-005.

1-008.02E Place of Application: The local office in the county where the individual resides is responsible for taking the application. Applications may be taken in the local office, in the applicant's home, or another place that is convenient for the applicant. If the client has a guardian, conservator, or other representative, the local office in the county where the representative resides may take the application.

Any individual may apply for medical assistance with a designated provider who has contracted with the Department to process Medicaid applications at their location. Form DA-100M is used for the application.

{Effective 10/1/97}

1-008.02F Withdrawals: The applicant may voluntarily withdraw an application. If the applicant verbally withdraws the application, the worker must request a written statement of withdrawal. The worker must make note of the withdrawal in the case record and give written confirmation of withdrawal to the applicant on a Notice of Action (see 469 NAC 1-008.03C).

If the applicant does not provide written confirmation of the withdrawal within 30 days from the application date, the worker must reject the application. The worker must send a Notice of Action to the applicant notifying him/her of the rejection.

1-008.02G Authorization for Investigation: For some sources the worker asks the client to sign a Release of Information when it appears that information given is incorrect, when the client is unable to furnish the necessary information, or for sample quality control verification. A copy of the authorization for release of information from the Application for Assistance may be used if the source will accept it.

1-008.02H New Application: A new application is required after one calendar month of ineligibility.

1-008.03 Notice of Finding: The worker must send adequate notice using a Notice of Action to notify the client of any action affecting his/her assistance case. The Notice of Action must be sent to the last-reported address. If the form is inadvertently sent to the wrong address, the worker must send a new form, allowing the client ten days from the date the corrected form is sent (if adequate and timely notice is required). If the client resides in a skilled nursing care, intermediate care, or long term care facility, a copy of the Notice of Action must be sent to the facility.

{Effective 10/1/97}

1-008.03A Types of Notices

1-008.03A1 Adequate Notice: An adequate notice must include a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s). The worker must send an adequate notice no later than the date of action.

1-008.03A2 Timely Notice: A timely notice must be dated and mailed at least ten calendar days before the date that action would become effective, which is always the first day of the month.

1-008.03B Adequate and Timely Notice: In cases of intended adverse action (action to discontinue, terminate, suspend, or reduce assistance or to change the manner or form of payment or service to a more restrictive method, i.e., protective payee, medical lock-in), the worker must give the client adequate and timely notice.

1-008.03C Situations Requiring Adequate Notice: In the following situations, the worker may dispense with timely notice but shall send adequate notice no later than the effective date of action.

1. The agency has factual information confirming the death of a client;
2. The agency receives a written and signed statement from the client -
   a. Stating that assistance is no longer required; or
   b. Giving information which requires termination or reduction of assistance, and indicating, in writing, that the client understands the consequence of supplying the information;
3. The client has been admitted or committed to an institution, and no longer qualifies for assistance;
4. The client has been placed in skilled nursing care, intermediate care, long-term hospitalization, or Assisted Living Waiver;
5. The client's whereabouts are unknown and agency mail directed to the client has been returned by the post office indicating no known forwarding address. The agency shall make the client's check available to the client if his/her whereabouts become known during the payment period covered by a returned check;
6. The client has been accepted for assistance in another state and that fact has been established;
7. A change in level of medical care; or
8. A special allowance granted for a specific period is terminated and the client has been informed in writing at the time of initiation that the allowance automatically terminates at the end of the specified period.

{Effective 5/11/99}

1-008.03D Waiver of Notice: If a client agrees to waive his/her right to a timely notice in situations requiring timely notice, the worker shall obtain a statement signed by the client to be filed in the case record.

1-008.03E In Fraud Cases: At least five days' advance written notice must be given if -

1. The agency has facts indicating that action should be taken to discontinue, suspend, terminate, or reduce assistance because of probable fraud by the client; and
2. The facts have been verified where possible through collateral sources.

1-008.03F Continuation of Benefits: In cases of adverse action where the worker is required to send timely and adequate notice, if the client requests an appeal hearing within ten days following the date Form IM-8 is mailed, the worker shall not carry out the adverse action until a fair hearing decision is made. This regulation does not apply to those situations outlined in 469 NAC 1-008.03C where the worker is required to send adequate notice only.

This regulation does not restrict the worker from continuing normal case activities and implementing changes to the assistance case that are not directly related to the appeal issue.

The worker shall not carry out an adverse action pending an appeal hearing if -

1. The case action being appealed required adequate and timely notice (see 469 NAC 1-008.03B and 1-008.03C);
2. The client requests an appeal hearing within ten days following the date the notice of finding is mailed; and
3. The client does not refuse continued assistance on Form DA-6.

If the worker's action is sustained by the hearing decision, the worker may institute recovery procedures against the client to recoup the disputed amount of assistance furnished the client during the appeal period (see 469 NAC 3-007.03B). Any amount of overpayment must be shown on the system so that it may be recouped if the client becomes eligible at a later date (see 469 NAC 3-007.03B).

1-008.03F1 Refusal of Continued Benefits: A client may refuse continuation of benefits pending an appeal hearing by checking the statement to that effect on Form DA-6 or handwriting a refusal.

1-008.03F2 Continuation of AABD/MA Benefits Pending an RSDI/SSI Appeal: If the worker receives information that the client has been determined no longer disabled by RSDI/SSI, the worker shall determine the last month that RSDI/SSI benefits are payable. Then the worker shall close the case the first month possible taking into account the advance notice requirement, unless -

1. The client files an appeal of RSDI/SSI's determination and will continue to receive benefits pending the appeal; and
2. The client loses the appeal because the administrative law judge determines that the client is not disabled. In that case the worker shall close the case as soon as the appeal decision is reached, taking into consideration the ten-day notice requirement.

1-009 Redetermination of Eligibility: The worker shall redetermine eligibility according to the following material. Whenever there is reported or suspected ineligibility of a client, the worker shall take immediate action.

1-009.01 Complete Redetermination: The worker must do a complete redetermination of eligibility every 12 months. The worker may use either a new or a previously completed application. Eligibility may be redetermined in less than 12 months to coordinate review dates for more than one program.

If the client is eligible for medical assistance only or medical assistance with Share of Cost but no further medical needs are apparent or indicated, or the case is ineligible, the worker must close the case and send a ten-day notice. The worker must determine if the client has a medical need by discussing the situation with the client, using the client's medical profile, etc. The worker closes the case if there is no medical need.

Note: The worker must explain on the notice of action that the client may reapply if there is a medical need at a later date.

In addition to the complete redetermination, the worker must complete income, resource, and disability reviews as described in following material.

1-009.01A Redetermination for SSI Recipients: The worker is not required to complete an application at the time of redetermination for clients who are receiving SSI.

If SSI is discontinued and the last application was completed more than 12 months from the last month of eligibility for SSI, the worker must conduct a complete redetermination of eligibility within the next 30 days, including completion of an application. If it has been less than 12 months since completion of the last application, the worker must review all eligibility requirements that are necessary for continued assistance.

Exception: A redetermination is not required for periodic non-pay for income due to an extra pay period.

Note: Clients who are determined eligible for Medicaid by SSI under the provisions of 1619(b) are not required to complete an application at redetermination. The worker does not need to verify resources (see 469 NAC 2-009.01). The worker must verify income and budget it for grant (see 469 NAC 2-010.01C and 3-006.01).

1-009.02 Income Review: The worker must review income eligibility every six months for AABD/MA and SDP/MA. This review may be eliminated for cases where the only source of income is RSDI or another similar stable source of income, and there is no reason to believe the amount will change. Irregular income must be verified every three months (see 469 NAC 2-010.01B3).

An income review is not required for SSI recipients. Income must be reviewed for clients who are placed in 1619(b) status by SSI.

1-009.03 Disability Review: Workers must complete procedures for review of disability for SDP/MA or AABD/MA cases (see 469-000-329) as required by the State Review Team on Form DM-5R, "Disability Report," which is every six months for SDP/MA and may be every 12 months for AABD/MA.

1-010 Prudent Person Principle: When the statements of the client are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the worker must obtain additional verification before eligibility is determined. The client has primary responsibility for providing verification of information relating to eligibility.

Verification may be supplied in person, through the mail, or from another source (as an employer). If it would be extremely difficult or impossible for the client to furnish verification in a timely manner, the worker shall offer assistance.

1-011 Local Office Responsible for Case Handling: The local office that serves the county where a client resides is responsible for handling the case. If the client has a guardian, conservator, or other representative, the local office in the county where the representative resides may handle the case.

Exception: The cases of an AABD couple with different counties of residence must be handled by one local office. If one spouse is in a long term care facility and the other is not, the local office in the county where the spouse is not in the long term care facility handles the case.

1-011.01 Transfer to New County of Residence: For procedures, see 469-000-311.

1-011.01A Case Handling of Temporary Absences: The case of an individual in an institution or a care facility for a temporary stay remains with the original local office in the county where the client resides and intends to return. Similarly, if a client is out of his/her county of residence for a brief visit the case is not forwarded. It remains the responsibility of the local office in the county where the client intends to return.

1-012 Summary of Forms: For a listing of forms used in AABD/MA and SDP/MA, see 469-000-328. Instructions for the forms are contained in the Public Assistance Forms Manual.